Nutritional/Medical Intake

General Information

Date:

Name			
Preferred Name			
Date of Birth		Age:	Gender: ☐ M ☐ F
Genetic Background	☐ African American ☐ Native American ☐ Mediterranean	☐ Hispanic ☐ Caucasian ☐ Northern European	☐ Asian ☐ Other *(please note)*
ABO Blood Type	*(circle one)* **O A B AB**	Have you ever had a blood transfusion? **Y N**	
Address			
Home Phone			
Cell Phone			
Work Phone			
Fax			
Email			
Best Way to Reach?			
Job Title/Employer			
Nature of Business			
Primary Physician	*Name:*		
	City:	*Phone:*	
Referred by			

Notes:

Complaints/Concerns

What do you hope to achieve in your visit?

If you had a magic wand and could erase three problems, what would they be?
(list you three main health/nutrition concerns)

1	
2	
3	

When was the last time you felt well?	
Did something trigger your change in health?	

What makes you feel better?	
What makes you feel worse?	
What is the lowest body weight that you have been comfortably able to maintain for at least 2 years in your adult life, since around age 30?	
Notes:	

Allergy Information

Please list FOOD allergies	
Please list NON-FOOD allergies	
What type of allergic symptoms do you experience?	

Medical History

	Height:	Weight:	Waist:

Please check those health conditions that your doctor has diagnosed (provide the date of onset)

GASTROINTESTINAL

- ☐ Irritable Bowel Syndrome
- ☐ Inflammatory Bowel Disease
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Gastric or Peptic Ulcer Disease
- ☐ GERD (reflux/heartburn)
- ☐ Celiac Disease
- ☐ Hepatitis C or Liver Disease
- ☐ Other Digestive:

INFLAMMATORY/AUTOIMMUNE

- ☐ Chronic Fatigue Syndrome
- ☐ Rheumatoid Arthritis
- ☐ Lupus SLE
- ☐ Poor Immune Function *(frequent infections)*
- ☐ Severe Infectious Disease
- ☐ Herpes-Genital
- ☐ Multiple Chemical Sensitivities
- ☐ Gout
- ☐ Other:

CARDIOVASCULAR

- ☐ Heart Disease (heart attack)
- ☐ Stroke
- ☐ Elevated Cholesterol
- ☐ Irregular heart rate – Pacemaker
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolapse/heart murmur
- ☐ Other Heart & Vascular:

METABOLIC/ENDOCRINE

- ☐ Diabetes ☐ Type 1 or ☐ Type 2
- ☐ Metabolic Syndrome (insulin resistance)
- ☐ Hypoglycemia
- ☐ Hypothyroidism (low thyroid)
- ☐ Hyperthyroidism (overactive thyroid)
- ☐ Polycystic Ovarian Syndrome (PCOS)
- ☐ Genetic Disorder: _____
- ☐ Other:

RESPIRATORY

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Sinusitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sleep Apnea
- ☐ Other:

MUSCULOSKELETAL/PAIN

- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Chronic Pain
- ☐ Migraines
- ☐ Other:

Medical History (continued)

Please note any past or current injuries:

NEUROLOGICAL/MOOD		CANCER
☐ Depression	☐ Bipolar Disorder	☐ Cancer *(please describe type and treatment)*
☐ Anxiety	☐ ADD/ADHD	
☐ Autism	☐ Multiple Sclerosis	
☐ Seizures	☐ Other:	

OTHER		
☐ Kidney stones	☐ Anemia	Please any other diseases or health conditions.
☐ Eczema	☐ Urinary (UTIs)	
☐ Psoriasis	☐ Frequent Yeast	
☐ Acne	☐ OTHER:	

MEDICATIONS (Please list all prescribed medications you are taking and note reason.)

Name:	*Reason:*
Name:	*Reason:*
Name:	*Reason:*
Name:	*Reason:*
Name:	*Reason:*
Name:	*Reason:*

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.) Motrin, Aspirin? ☐ Y ☐ N

Have you had prolonged or regular use of Tylenol? ☐ Y ☐ N

Have you had prolonged or regular use of acid-blocking drugs (Tagamet, Zantac, etc.)? ☐ Y ☐ N

Frequent antibiotics >3 times per year? ☐ Y ☐ N Long term antibiotics? ☐ Y ☐ N

Medical Symptoms Questionnaire (MSQ)

Name: **Date:**

Rate each of the following symptoms based upon your typical health profile for:

☐ *Past 30 days* ☐ *Past 48 hours*

Point Scale

0 – *Never* or *almost never* have the symptom
1 – *Occasionally* have it, effect is *not severe*
2 – *Occasionally* have it, effect is *severe*
3 – *Frequently* have it, effect is *not severe*
4 – *Frequently* have it, effect is *severe*

HEAD

____ Headaches
____ Faintness
____ Dizziness
____ Insomnia TOTAL _____

EYES

____ Watery or itchy eyes
____ Swollen, reddened/sticky eyelids
____ Bags, dark circles
____ Blurred or tunnel vision *(does not include near or far-sightedness)*

TOTAL _____

EARS

____ Itchy ears
____ Earaches, ear infections
____ Drainage from ear
____ Ringing /hearing loss

TOTAL _____

NOSE

____ Stuffy Nose
____ Sinus problems
____ Hay fever
____ Sneezing attacks
____ Excessive mucous

TOTAL _____

MOUTH/THROAT

____ Chronic coughing
____ Gagging/throat clearing
____ Sore throat, hoarseness
____ Swollen/discolored tongue, gums, lips
____ Canker sores TOTAL _____

HEART

____ Irregular /skipped beats
____ Rapid/pounding beats
____ Chest pain

TOTAL _____

SKIN

____ Acne
____ Hives, rashes, dry skin
____ Hair loss
____ Flushing, hot flashes
____ Excessive sweating

TOTAL _____

LUNGS

____ Chest congestion
____ Asthma, bronchitis
____ Shortness of breath
____ Difficulty breathing

TOTAL _____

DIGESTIVE TRACT

____ Nausea, vomiting
____ Diarrhea
____ Constipation
____ Bloated feeling
____ Belching, passing gas
____ Heartburn
____ Intestinal/stomach pain

TOTAL _____

JOINTS/MUSCLE

____ Pain or aches in joints
____ Arthritis
____ Stiffness/limited movement
____ Pain or aches in muscles
____ Feeling of weakness or tiredness

TOTAL _____

WEIGHT

____ Binge eating/drinking
____ Craving certain foods
____ Excessive weight
____ Compulsive eating
____ Water retention
____ Underweight

TOTAL _____

ENERGY/ACTIVITY

____ Fatigue/sluggishness
____ Apathy, lethargy
____ Hyperactivity
____ Restless leg
____ Jetlag

TOTAL _____

MIND

____ Poor memory
____ Confusion, poor comprehension
____ Poor concentration
____ Poor physical coordination
____ Difficulty making decisions
____ Stuttering or stammering
____ Slurred speech
____ Learning disabilities

TOTAL _____

EMOTIONS

____ Mood swings
____ Anxiety, fear, nervousness
____ Anger, irritability, aggressiveness
____ Depression

TOTAL _____

OTHER

____ Frequent illness
____ Frequent or urgent urination
____ Genital itch or discharge
____ Bone pain

TOTAL _____

GRAND TOTAL_____

Surgeries/Hospitalizations

Please list any surgeries or hospitalizations (include dates and your ages if known).

Family History

Please note any family history of the following diseases: *heart disease, cancer, stroke, high blood pressure, overweight, lung disease, kidney disease, diabetes, cancer, mental illness or addiction.*

Family Member:	*Health Condition:*
Family Member:	*Health Condition:*
Family Member:	*Health Condition:*
Family Member:	*Health Condition:*
Genetic Disorders Known:	

Notes:

Dental History

Do you have any silver/mercury amalgam fillings? ☐ Y ☐ N If **Y**, how many?

Do you have any ☐ Gold fillings ☐ Root canals ☐ Implants ☐ Bridges ☐ Crowns

Do you have any ☐ Tooth pain ☐ Bleeding gums ☐ Gingivitis ☐ Chewing problems

Do you visit a dentist regularly (twice per year)? ☐ Y ☐ N

Have you ever had an infection in your jawbone? ☐ Y ☐ N

TMJ: ☐ grinding teeth ☐ jaw clicking ☐ braces? If yes, what age ____ ☐ surgery ☐ jaw pain

Teeth: ☐ extraction? How many? _____ ☐ Which teeth are missing? (# or name)_____

Additional Medical Notes:

Nutrition History

Have you ever had a nutrition consultation? ☐ Y ☐ N

Have you made any changes in your eating habits because of your health? ☐ Y ☐ N

Please describe.

Do you currently follow a special diet or nutritional program? ☐ Y ☐ N

Check all that apply.

☐ Low fat	☐ Low Carb	☐ High protein	☐ Low sodium
☐ No Gluten	☐ Vegetarian	☐ Vegan	☐ Diabetic
☐ No Dairy	☐ No Wheat	☐ Weight Loss	☐ Other _____

How often to you weigh yourself?

Have you had any recent history of weight loss or weight gain? If so, please describe.

How many meals per day do you eat? How many snacks?

Do you avoid any particular foods? *If yes, describe.*	
If you could only eat a few foods a week, what would they be?	
How many meals do you eat out per week?	☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ more than 5 per week

Check all the factors that apply to your current lifestyle and eating habits:

☐ Fast eater	☐ Family member have different tastes
☐ Erratic eating patterns	☐ Love to Eat
☐ Eating too much	☐ Eat because I have to
☐ Late night eating	☐ Have a negative relationship to food
☐ Dislike healthy food	☐ Struggle with eating issues
☐ Time constraints	☐ Emotional eater (stress, bored, etc.)
☐ Travel frequently	☐ Confused about food/nutrition
☐ Do not plan meals or menus	☐ Frequently eat fast foods
☐ Rely on convenience items	☐ Poor snack choices

Nutrition History (continued)

What are the top three dietary changes do you think would make the most difference in your overall health?	1. 2. 3.
How committed are you to making dietary changes in order to improve your health?	*not committed* 1 2 3 4 5 *very committed*

Please list all **nutritional supplements** you currently take daily. Please include brand names and amounts as well as any herbs/botanical products.

Do you drink alcohol? ☐ Y ☐ N If yes, how many drinks per week?

Do you drink coffee or other caffeinated beverages? ☐ Y ☐ N If yes, # daily?

Do you use artificial sweeteners? ☐ Y ☐ N If yes, which ones?

Do you feel like belching or are you bloated after eating? ☐ Y ☐ N

Do you have (or had) any eating disorders? ☐ Y ☐ N If yes, please describe.

Were you breastfed as an infant (if known)? ☐ Y ☐ N

Please note anything additional about your nutrition/eating habits.

Current Eating Habits

Mark the meals you eat regularly: ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacks

Where do you obtain your food from: ☐ home prepared from whole foods ____% ☐ organic ___%

☐ home prepared convenience food ____% ☐ eat out ____%

Mark how many times you eat or drink the following items **PER WEEK**:

___ Soda (regular)
___ Soda (diet)
___ Alcohol
___ Hot tea
___ Cold tea
___ Coffee (regular)
___ Coffee (decaf.)
___ Sugar in coffee
___ Coffee drinks
___ Sweetened drinks
___ Sparkling water
___ Purified water
___ Tap water
___ Fruit juice
___ Lemonade
___ Milk (cow)
___ Milk (goat)
___ Soy Milk
___ Rice Milk
___ Nut Milk
___ Herbal teas

___ Fast food
___ Candy
___ Ice cream
___ Pudding
___ Refined sugars
___ Tuna fish
___ Swordfish
___ Sushi/sashimi
___ Salmon/other fish
___ Lunch meats
___ Bacon
___ Hot dogs
___ Whole eggs
___ Red meat
___ Poultry
___ Tofu
___ Tempeh/Miso
___ Vegetarian foods

Artificial Sweeteners:

___ Equal/Nutrasweet (Aspartame)
___ Splenda (sucralose)
___ Saccharin
___ Stevia/Xylitol

___ Dried fruit
___ Canned fruit
___ Fresh Fruit
___ Jelly/jam
___ Sweets (cookies)
___ Green Salads
___ Raw veggies
What kind?

___ Cooked veggies
What kind?

___ Potatoes
___ Yams/Sweet Potatoes
___ Popcorn
___ Cereals
___ Oatmeal
___ Bagels/pretzels
___ White bread
___ Sprouted Br.
___ Wheat Bread

___ Crackers
___ Pasta
___ Brown rice
___ White rice
___ Corn tortillas
___ Flour tortillas
___ Potato Chips
___ Tortilla Chips
___ Pizza
___ Yogurt (plain)
___ Yogurt (sweet)
___ Prepared meals (Lean cuisine, etc.)
___ Microwave meals/soups
___ Restaurant meals (healthy)
___ Restaurant meals (unhealthy)
___ Airplane meals
___ Legumes (beans, lentils)

NOTES:

24 Hour Diet & Supplement Diary / Exercise / Sleep Log

Day __	Date:
Wake up time:	
Morning Meal Time:	
Snack Time:	
Mid-Day Meal Time:	
Snack Time:	
Evening Meal Time:	
Snack Time:	
Water (Ounces)	
Other Drinks (that are not listed with meals or snacks above)	
Activity/Exercise What kind: How Long:	
Relaxation Type: How Long:	
Sleep Time:	
Rx Medications:	

Name_____

Please Complete your "Diet Diary/Exercise Log"

1. Make note of the time you wake up

2. List and describe in detail all foods and drinks including the amount of each. Make note as to whether the food was fresh, frozen, canned, raw, cooked, baked, fried, etc. Note the time of each meal or snack. Be sure to list everything you eat or drink, including any condiments used (i.e. mayonnaise, mustard relish, etc.).

3. Keep track of how much water you drink and list the amount in ounces in the section provided. Also note the type and amount of any other drinks you consume.

4. Write down any activity or exercise you do in the section at the bottom, listing the kind of exercise you did and for how long you did it.

5. Note any periods of relaxation and what kind of relaxation it was.

6. Note the time you go to sleep.

Supplements:

_____ dose _____
_____ dose _____
_____ dose _____
_____ dose _____
_____ dose _____
_____ dose _____
_____ dose _____
_____ dose _____
_____ dose _____
_____ dose _____
_____ dose _____
_____ dose _____
_____ dose _____

□ Nutritionist/Doctor Recommended
□ Personal selection

Fats and Oils

Please indicate how many times PER WEEK you eat the following fats/oils.

OMEGA 9 *(stabilizer)* ~50% of daily fat calories Oleic Fatty Acid	___ Almond Oil ___ Almonds/Cashews ___ Almond butter ___ Avocados ___ Peanuts ___ Peanut butter (natural)	___ Olives ___ Olive Oil ___ Sesame Seeds ___ Hummus ___ Macadamia Nuts ___ Pine Nuts
OMEGA 6 *(controllers)* *Essential Fatty Acid Family* *~30% of daily fat calories* LA ➔ GLA ➔ DGLA ➔ AA	___ Eggs (whole), organic ___ Meats (commercial) ___ Meats (grass-fed, org.) ___ Pumpkin seeds (raw) ___ Brazil nuts (raw) ___ Pecan (raw) ___ Hazelnuts (raw)	___ Evening Primrose Oil (GLA) ___ Black Currant Oil (GLA) ___ Hemp Oil ___ Grapeseed Oil ___ Sunflower Seeds
OMEGA 3 *(fluidity/communicators)* *Essential Fatty Acid Family* *~10% of daily fat calories* ALA ➔ EPA ➔ DHA	___ Fish Oil supplement ___ Fish (salmon/fin-fish) ___ Fish (shellfish) ___ Flax Oil ___ Flax seeds/meal	___ UDO's DHA Oil ___ Algae ___ Super-food Greens w/algae ___ Chia seeds
BENEFICIAL SATURATED *(structure)* *~10% of daily fat calories* Short Chain/Medium-chain Triglycerides	___ Coconut Oil ___ Butter, organic ___ Ghee (clarified butter) ___ Dairy, raw & organic	___ Meats, grass-fed ___ Wild game ___ Poultry, organic ___ Eggs, organic
DAMAGED FATS/OILS (promoting stress to cells & tissues) *Should be <5% (try to avoid)* Trans Fats Acrylamides Odd-Chain Fatty Acids VLCFA/damaged	___ Margarine ___ Reg. vegetable oils (corn, sunflower, canola) ___ Mayonnaise ___ Hydrogenated Oil (as an ingredient) ___ "Imitation" cheeses ___ Tempura	___ Doughnuts (fried) ___ Deep-fried foods ___ Chips fried in oil ___ Reg. Salad dressing ___ Reg. Peanut Butter ___ Roasted nuts/seeds ___ Non-dairy products

Lifestyle Information

Do you engage in moderate cardiovascular physical activity at least 3 days a week, for a minimum of 20 minutes duration? (brisk walking, jogging, hiking, cardio exercise classes, cycling, stair-climbing, etc.)

☐ Y ☐ N

ACTIVITY	TYPE/INTENSITY *(low-moderate-high)*	# DAYS/WEEK	DURATION *(minutes)*
Stretching/Yoga			
Cardio/Aerobics			
Strength Training			
Sports or Leisure			

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Med ☐ High

Note any problems that limit your physical activity.

Do you smoke? ☐ Y ☐ N	How many years?
Packs per day?	2nd hand smoke exposure? ☐ Y ☐ N
Excess stress in your life? ☐ Y ☐ N	Easily handle stress? ☐ Y ☐ N

Daily Stressors: *Rate on a scale of 1 (low) to 10 (high)*

☐ Work____ ☐ Family____ ☐ Social____ ☐ Finances____ ☐ Health____ ☐ Other:____

Do you feel your life has meaning and purpose? ☐ Y ☐ N ☐ unsure	Do you believe stress is presently reducing the quality of your life? ☐ Y ☐ N
Average number of hours you sleep per night **during the week**?	Average number of hours you sleep per night **on weekends**?
Trouble falling asleep? ☐ Y ☐ N	Rested upon waking? ☐ Y ☐ N

Do you wake up during the night? ☐ Y ☐ N If yes, how many times?

How would you rate the overall quality of your sleep? *low quality* 1 2 3 4 5 *high quality*

Note the approximate times you generally wake during the night.

Environmental Information

Do you have known adverse food reactions or sensitivities? ☐ Y ☐ N	If yes, please describe symptoms.

Are you exposed regularly to any of the following? *(check all that apply)*		Please note any regular exposure to harmful chemical/substances?
☐ Cigarette smoke	☐ Perfumes	
☐ Auto exhaust/fumes	☐ Paint fumes	
☐ Dry-cleaned clothes	☐ Mold	
☐ Nail polish/hair dyes	☐ Pesticides	
☐ Heavy metals	☐ Fertilizers	
☐ Teflon Cookware	☐ Pet dander	
☐ Aluminum Cookware	☐ Chemicals	

Do you use any recreational drugs? If so, please note.	

Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing)

In order to improve your health, how willing are you to:

Significantly modify your diet	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Take several nutritional supplements each day	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Keep a record of everything you eat each day	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Modify your lifestyle (e.g., work demands, sleep habits, exercise)	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Practice a relaxation technique	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Engage in regular exercise/physical activity	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Have periodic lab tests to assess your progress	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

How much on-going support and contact (e.g., telephone, e-mail) from the nutritionist would be helpful to you as you implement your personal health program?